Health Education North Central and East London
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Developing people for health and healthcare

Pan-London Quality and Regulation Unit

University College Hospitals NHS Foundation Trust

Trust Wide Review

Quality Visit Report

Date of visit: 2 June 2015

Final

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Health Education
North Central and East London

TRUST-WIDE REVIEW

Visit Details	
LEP	University College London Hospitals NHS Foundation Trust
Date of visit	2 June 2015
Background to visit	The Trust was formally visited on 15 October 2012 for the Annual Quality Visit. The Pan-London Quality and Regulation Unit organised this Trust-wide review on behalf of Health Education North Central and East London to review the education, training and governance of the Trust. Obstetrics and gynaecology and General Practice were visited in parallel specialty focused visits. The GMC National Training Survey (GMC NTS) results for 2014 did not have any significant negative outliers for the Trust. The main concerns were the red outliers in overall satisfaction in some specialties. The induction programme generated 11 pink outliers and one red outlier in paediatrics.
Visit summary and outcomes	The visit team met with the postgraduate education team, including the associate director of medical and dental education, director of postgraduate medical education, director of education, associate director of clinical education, joint academic support manager for library services and the medical education manager. The meeting with the senior management team was attended by the chief executive, director of education, director of postgraduate medical education, head of finance, head of workforce and training programme directors in foundation and core medicine. The Trust met with over 30 trainees, some of which were trainee representatives from all grades of training except foundation. The visit team met with many educational leads from across the Trust. Finally, the visit team provided feedback to the chairman, the medical director, associate director of medical and dental education, director of postgraduate medical education, director of education and educational leads. The visit team were pleased with the attendance and engagement of the visit by all staffing groups. The trainees appeared to be receiving excellent supervision and learning experiences. The trainees would all recommend the post to colleagues for training. The visit team congratulated the Trust on its reconfiguration of the educational structure. The Trust's vision of taking the educational strategy forward was excellent, and both trainees and trainers reported that the work completed so far was positive. The visit team heard that Trust was currently reviewing job plans. The visit team recommended that for the educational work to continue, dedicated time in job plans should be allocated. The visit team were concerned to hear of the lack of space available to undertake private / confidential meetings, or to provide hands-on training. The Trust was encouraged to look at the process of reorganisation and ensure that opportunities were not compromised. There were reports from trainees regarding the uncertainty and confusion of pathways for paediatric patients under two years of age. The Trust was required to clarify the pathway and communicate it to all staff in an effort to reduce trainee anxiety and limit potential patient safety concerns. The Trust was issued with three immediate mandatory requirements for potential patient safety concerns. Further details can be found in the report below, but these related to:

	• A potential lack of handover resulting in a compromise in patient safety for private oncology and/or haematology patients. • Locum doctors not receiving an induction and trainees regularly sharing electronic log-in details for locums to access patient records. • A lack of safe staffing and skill mix (nursing) for the care of patients including 1-6 patients with airway needs on the T14 ward. Overall, the visit team were satisfied with the excellent training being delivered in the Trust. The engagement of the consultant body and senior management team was apparent and was acknowledged by the visit team.

Visit team

Lead Visitor	Dr Indranil Chakravorty, Trust Liaison Dean	**Trust Liaison Dean**	Dr Andrew Deaner, Trust Liaison Dean
LETB Representative	Miss Andrea Dewhurst, Quality and Performance Manager	**Lay Member**	Mrs Farrah Pradhan, Lay Representative
Visit Officer	Miss Michelle Turner, Quality and Visits Officer		

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
1	TWR 1.1	**Handover** The trainees reported that there were concerns with the care of the private oncology ward out of hours. The trainees did not work in the ward during normal hours, but were expected to cover the ward at night and weekends. The evening handover did not include the oncology private ward, and so the on call team were unaware of the patients. Patients were admitted directly to the ward without triaging. There was no out of hours cover on the ward; haematology was well covered at night but oncology was not. The oncology junior doctor covered all cancer patients out of hours, and the visit team felt that this was a potential patient safety issue. The doctor on call was contacted by telephone when patients were admitted. But the patients were not assessed or reviewed in order of clinical priority. This resulted in patients not being seen in a timely fashion and a lack of understanding of who should be reviewing the patients. The visit team heard of an example when the oncology junior doctor covering the weekend was bleeped by nurses to review a deteriorating patient, but as a result of the workload out	The visit team were made aware of a lack of handover and potential patient safety compromises in private oncology/ haematology patients. There was a lack of clear policies for care out of hours. The Trust is required to review the standard operating policy, implement a robust and safe handover and clinical responsibility for these patients out of hours.	**Red** Immediate Mandatory Requirement

		of hours, the patient had died before being reviewed. The trainees commented that the handover in otolaryngology was formal. There were two sides to the handover: the head and neck on-site team handed over directly to the on call junior trainee and there was also a senior trainee to senior trainee handover. All handovers were also recorded on the head and neck database. The educational leads stated that the private wing (T15) was for haematology and oncology patients. The cover arrangements had changed in February 2015. During normal hours the ward was staffed by clinical fellows, and out of hours the ward was covered by the on call oncologist or haematologist. The educational leads confirmed that the issue of inadequate staffing had been highlighted by trainees in the weeks prior to the visit. There was a haematology senior trainee, haematology junior trainee and an oncology junior trainee on the ward. The visit team heard that inpatient numbers meant that there was no need for an increase in staffing the majority of the time as there were two on call doctors for 20 haematology patients. The senior trainees were being pulled away more regularly due to emergencies and there had been an increase in patients requiring review on a daily basis. The visit team heard that the educational leads had not been made aware previously that this was happening; they confirmed that the department was looking to address this and the practice would stop henceforth.		
1	TWR 1.2	**Patient Safety – Staffing** Trainees reported that the head and neck ward (T14) was of particular concern because of the chronic understaffing of skilled nurses which had resulted in potentially sub-optimal care being provided. Historically, the ward had been staffed by experienced nurses; many of these nurses had left and had been replaced with less experienced nurses. The Trust was in the process of recruiting senior nurses, but this had proved difficult. As an interim measure, senior nurses from other units were rotated into the ward. The visit team heard that the ward had thirty beds, and up to six of the patients had tracheostomies. Out of hours the ward was staffed with two nurses and healthcare assistants. This had been the case for nearly three years. The trainees stated that they were not aware of any adverse incidents occurring as a result of the staffing levels. The pressure on the staff out of hours, with only two trained nurses, was significant. The	The visit team were made aware of a lack of safe staffing (nursing) for the care of patients on T14 (OMFS & ENT), including 1-6 patients with airway needs. The Trust is required to review the nursing ratios for the T14 ward and ensure that patient care is safe. The review report will need to be sent to the Pan-London Quality and Regulation Unit.	**Red** Immediate Mandatory Requirement

		airways patients were well looked after but required a greater amount of nurses' time, which put significant demand on the nurses and possibly resulted in other patients experiencing delays in care and treatment. The trainees commented that there had been an increase in wound issues, skin graft failures and infections, all which were potentially affected by the limited nursing cover.		
1	TWR 1.3	**Patient Safety – Induction** The trainees reported that locums did not receive an induction into the department. There was no generic locum electronic log-in available, and as a result junior trainees had shared their log-in details with the locums, in order for them to access the systems and patient records. The visit team heard that the emergency medicine higher trainees felt it was their responsibility to induct locums into the department, and therefore they took them on a tour of the facilities. The visit team heard that if the trainees were unhappy with the standard or training of a locum, they were able to report this to senior colleagues. Locums deemed unsatisfactory had not returned to the Trust.	The visit team were made aware of locum doctors (in areas other than the emergency department) not receiving an induction and trainees having to share electronic log-in to patient records. The Trust should create temporary log-ins and a brief induction pack for locum doctors. Trainees must not share log-in passwords.	**Red** Immediate Mandatory Requirement
1	TWR 1.4	**Patient Safety - Paediatric Pathways** The otolaryngology (ENT) trainees reported that the department did not have paediatric airways equipment for patients under two years old. This had been raised at clinical governance meetings and the department had looked at setting up a pathway. There was no assigned cover in the Trust, as it was a rare occurrence, but there was an informal agreement with the anaesthetists that they would assist. The trainees reported that if a patient deteriorated over night, they would immediately call the consultants, who were within 30 minutes of the main hospital. The trainees stated that they would probably be adequately supported if a difficult scenario occurred, but it was not explicitly clear what would happen. The trauma and orthopaedic trainees commented that patients under two should not be admitted into the Trust; the pathway was for them to be treated at the Royal Free Hospital. The official line was to not accept patients under two, but if the Trust was forced into the situation, there were mechanisms in place to appropriately cover. The educational leads commented that all paediatric patients requiring anaesthesia or	There was confusion regarding the pathway for paediatrics patients under the age of two. The Trust is required to clarify the current pathway and ensure this is clearly communicated to all staff.	**Amber** Mandatory Requirement

		airways support were covered by the general on call rota. Trainees had been told to let consultants know that they would come in out of hours. All anaesthetists were deemed competent and able to look after the emergency situation of an unwell paediatric patient. The challenge was when the anaesthetist was not comfortable or confident in doing so. For very young patients, the neonatal team was also on call for support. The surgery educational leads commented that historically the paediatric beds in ENT were at the Royal Free Hospital. There was an anaesthetist resident on call until 10pm who was able to act as the general liaison. The educational leads commented that the pathway was being looked at by the Trust and Great Ormond Street Hospital for Children NHS Foundation Trust to ensure the support available was appropriate.		
1	TWR 1.5	**Clinical Supervision** The visit team heard that there was a consultant on long term sick leave in audiovestibular medicine which had resulted in trainees covering the neuro-otology clinics at the National Hospital for Neurology and Neurosurgery without direct consultant supervision. The trainees were able to meet with another consultant and discuss patients at the start of the clinic but there was not always a senior person directly available throughout the clinic. Many of the patients were new patients but were not acutely ill. The educational leads confirmed that all trainees were supervised by consultants during clinics. Clinics were not necessarily cancelled if consultants were off, but explicit details were sought regarding who was covering clinics. If consultants were not available directly in clinic there would be dedicated support in a parallel clinic.	Clinics without consultant supervision should be cancelled. In terms of the neuro-otology clinics at the National Hospital for Neurology and Neurosurgery Clinics, the trainees should be provided with full (if not direct) clinical supervision from an appropriate consultant.	**Amber** Mandatory Requirement
1	TWR 1.6	**Clinical Incident Reporting** The director of education commented that the Trust used the Datix system for reporting clinical incidents. The Trust received approximately 70 serious incidents per year; on receipt of an incident they were all ranked in terms of seriousness. If ranked as a serious incident the director of medical education (DME) was notified in order to provide support to trainees. Reports were followed up but the visit team heard that because of the size of the Trust it was a difficult task to ensure that all received feedback. The Trust was looking to improve the feedback mechanisms in place, to ensure that all trainees were supported and received feedback in a timely manner. The senior management team commented that the postgraduate medical education team		

		had been reviewing clinical incident reports to ensure all trainees were adequately supported and records were kept. Once incidents had been investigated the incident was fed back via action after review (AAR) sessions in order for lessons to be learnt. The visit team heard that the corporate medical director had responsibility for incidents and clinical risks. All reports were reviewed locally and then passed to the division and the patient safety board where necessary. The majority of trainees stated that they were aware of the process in place to report incidents and had received feedback. Trainees commented that the feedback following clinical incidents had been comprehensive. The trainees commented that the Trust appeared to be engaged and encouraged reporting. Monthly emails were circulated which detailed the Datix reports and outcomes of incidents. The trauma and orthopaedic trainees stated that they had clinical governance meetings in which clinical incidents were discussed. Emergency medicine trainees reported that they had never received feedback on Datix reports whilst in post in the Trust. The educational leads commented that the reporting system was well embedded into the Trust. They indicated that trainees may have concerns with the feedback mechanisms, as feedback was not always provided in a timely manner. This was the result of lengthy coroners' enquiries and trainees rotating etc. Where possible, the educational leads were providing feedback to trainees concurrently with investigations.		
1	TWR 1.7	**Whistleblowing** The education team stated that the whistleblowing policy was disseminated to trainees at the induction. Trainees were encouraged to raise concerns to their educational supervisor or the postgraduate department. The senior management team reported that the whistleblowing policy was highlighted at the Trust induction. The details of the policy were not discussed, but it was reinforced that the director of education was available to discuss any concerns no matter big or small. The trainees reported that they vaguely remembered the policy being mentioned at the induction but were unsure where it could be accessed. Trainees had been encouraged to raise concerns to educational supervisors or the postgraduate medical education team.		

		The trainees stated that the previous DME had set up regular drop-in clinics at lunchtimes which trainees could attend and discuss concerns confidentially, but they were unsure if this was still available. This had been put on hold whilst the newly appointed DME was settling into the role. The core surgery trainees commented that they had not heard of the whistleblowing policy but they felt supported enough to raise concerns to consultants if needed. The visit team heard that the director of workforce was the accountable officer for the whistleblowing policy. The policy was always discussed at the corporate induction and all staff were made aware of the policy from day one in the Trust. The educational leads reported that they were all aware of the Trust's whistleblowing policy and they thought that the trainees were aware of the policy and were confident and encouraged to discuss concerns if they arose.		
2	TWR 2.1	**Local Faculty Groups (LFGs)** The postgraduate medical education team reported that there was approximately 90% coverage of formal LFGs across the Trust. There were areas within the Trust where regular meetings were informal and minutes were not taken. Additional work was required to improve consistency of all LFGs. The majority of trainees were aware of there being LFGs within their specialty. The visit team heard of examples when issues had been raised and addressed satisfactorily. This included the purchase of new ultrasound machines in the radiology department. The visit team heard that the trainees in medical microbiology and infectious diseases were unaware of there being a trainee representative in either specialty. The trainees indicated that although the two specialties should be working together more they were still quite separate. The trainees stated that they were unaware of there being an acute medicine / general internal medicine LFG within the Trust. There was a monthly service education meeting in which the departments would discuss the data collected for emergency department patients admitted and discharged but it was not a forum for discussing issues such as rota concerns. The educational leads stated that there was a general medicine LFG which trainees were invited to attend to discuss concerns with regards to acute and general internal medicine	Please ensure that all trainees involved in the acute medicine on call rota are provided with the opportunity to attend the LFG or to feedback to a trainee representative whom will attend. Minutes of the LFG should be shared with the DME and sent to quality team.	**Amber** Mandatory Requirement

		but trainees rarely attended.		
2	TWR 2.2	**Governance** The postgraduate medical education team commented that previously there was one postgraduate medical education committee meeting per month. The attendance was good but engagement of attendees was poor as the meeting coverage was so broad. The visit team heard that new governance arrangements had been implemented and there were now three committees aligned to the Board. Trainee representative attendance had been introduced but some areas required further work on engagement and attendance but overall it was going well. The trainees reported that the medical director held a monthly forum for trainees to raise concerns; this was held in the Doctors' Mess. The visit team heard that through this forum, trainees had raised concerns with sick leave on night shifts and poor locum cover arrangements, which resulted in the junior doctors feeling exposed out of hours. The medical director had reviewed the concerns and the rota was much better organised and safe cover was in place.	The process of appointment of trainee representatives should be formalised. Communication with trainee representatives and their respective LFGs should be robust and DME to monitor attendance of trainee reps at LFGs.	**Amber** Mandatory Requirement
2	TWR 2.3	**Feedback** The education team reported that the end of post feedback questionnaire had been well received. It has been introduced to only foundation and core medical trainees. It had been helpful in identifying issues throughout the year, and was used in conjunction with the yearly GMC NTS results. The core trainees reported that they were unaware of the post feedback questionnaire; however, many of the trainees had not been in post longer than the current rotation.		
5	TWR 5.1	**Curriculum Requirements** The anaesthetics trainees reported that they had been able to meet the curriculum requirements, and were receiving a good experience. The visit team heard that there was a lack of understanding in the Trust with regards to the Acute Care Common Stem (ACCS) training programme. Trainees in ACCS in the intensive care unit had been asked why they were there by consultants. There was confusion by many of the staff with regards to the training requirements of the ACCS programme and trainee needs. The trainees commented that they felt isolated, but consultants had been supportive.	There was only one airway skills training session per year, which was an issue for the non-anaesthetics ACCS trainees rotating to anaesthetics in the second block of the year. The Trust should ensure that all ACCS trainees being rotated to anaesthesia receive formal training in airway management at appropriate time as part of induction.	**Amber** Mandatory Requirement

		Trainees in emergency medicine commented that airways training was organised in August but if trainees were in anaesthetics in their second block of the rotation, they would not have access to the airways skill training. This meant that the trainees were unable to work unsupervised during their time in post. The educational leads stated that the Trust did not have ACCS year two trainees in anaesthetics, but the year one trainees had completed the Trust training for airways competencies. The visit team heard that the Trust only had one sports and exercise NHS clinic per week. There was a lack of space which stopped the Trust being able to offer more clinics, although there was a need for more clinics in London. The patients seen in clinics were interesting and provided great learning opportunities. The core surgery trainees reported that they did not have protected theatre time in surgery. They held the bleep and had to negotiate with colleagues to carry the bleep in order to attend theatre. The trainees were also expected to cover the workload on the surgical ward which detracted from surgery time. The trainees commented that they often started work earlier, in order to complete their ward jobs earlier and attend surgery later. The surgery educational leads reported that the time in surgery for core trainees was variable. They were all supposed to be allocated to four sessions per week; it was part of the weekly programme to ensure they all gained relative experience. The surgery trainees reported that there was limited paediatric surgery in North Thames London which impacted on the training opportunities for surgery specialty trainees and anaesthetics trainees. The trainees confirmed that there was an agreement with Great Ormond Street Hospital NHS Foundation Trust which had issued honorarium contracts for trainees to attend theatre there. Trainees stated that the Trust was a good educational experience; the non-clinical aspects of training were also available which added to the opportunities on offer.	There was only one sports and exercise NHS clinic per week due to a lack of space. The Trust to review the opportunities available. The core surgery trainees were not consistently attending four operating lists per week. Trust TPD for Surgery should confirm that all surgical trainees have allocated 4 theatre sessions in their job plans and undertake an audit to confirm this.	**Green** Recommendation **Amber** Mandatory Requirement
5	TWR 5.2	**Acute Medicine** The specialty medicine trainees stated that they all received good support and clinical supervision whilst working in the acute medicine unit. There were regular consultant-led ward rounds, and the unit was well staffed in terms of junior doctors.	Specialty trainees contribute to the acute medical rota. However, there are historical variations in the individual specialties contributions and this has an effect in the GIM VS Specialty	**Amber** Mandatory Requirement

		The medicine trainees reported that every specialty had negotiated its input into the acute take, which meant there were many differences with the trainees' allocated time on the call rota. The visit team heard that some trainees felt the acute medicine rota was a burden which detracted from their specialty training. Trainees in infectious diseases and respiratory medicine had raised specific concerns about the amount of time they spend on the acute medicine rota which resulted in a loss of specialty training exposure. The trainees in diabetes and endocrinology commented that their acute rota was organised differently; they shared the commitment with a colleague but it was only for a six week period out of a six month block. However, during the six months without on call commitments the trainees did not receive on call banding. The trainees commented that there was minimal or no designated teaching within general internal medicine. Training sessions were consultant-dependent, and relied on enthusiastic acute medicine specialty trainees. The educational leads reported that the acute medicine rota issues were a common problem across training schemes. The acute medicine consultants had negotiated specialty trainee involvement on the on-call rota, which meant that many specialties had different commitments. The department was well staffed and supported. There was a move towards team working in acute medicine which had improved the support and staffing available and appeared to be working well.	components for each post. The Medicine LFG should review this 'variable contribution' and decide if this needs to be changed. This should be done in conjunction with all specialty leads and trainee reps. Minutes to be sent to Quality team.	
5	TWR 5.3	**Schwartz Round** The trainees working at the National Hospital for Neurology and Neurosurgery commented that Schwartz Centre Rounds had been implemented. They were a mechanism for all staff to discuss difficult emotional and social issues arising from patient care in an open forum. Trainees were able to present cases and discussions which they found educationally relevant.		
6	TWR 6.1	**Educational Supervision** The director of education stated that an in house supervisor training programme had been developed to ensure that all trainers were accredited. There had been a focus on ensuring all trainers were fully approved in their role. The Trust was at 90% compliance at the time of the visit. The education team commented that job planning was variable across the Trust. Some departments had been on top of this for a while and job plans reflected the work being		

		undertaken by staff. The anaesthetics department was a good example of where this had been completed well. The Trust was keen to improve the data records and link educational activity to funding received, and develop clear tariffs to recognise the responsibility of roles. The visit team heard that all educational supervisors were appraised and accredited by the director of postgraduate medical education (PGME); the local educational leads were able to complete training to undertake educational supervisors' appraisals themselves. The DME had started on an allocation of three supporting programmed activities (SPA). If the work proved to be onerous in the timescale this would be increased to four SPAs. The trainees stated that they had been allocated educational supervisors on starting in post and had met to discuss educational objectives. The visit team heard of incidents when educational supervisors in general internal medicine (GIM) had not been allocated until this had been raised as a concern at the trainee's penultimate year assessment (PYA). The educational leads reported that they all had variable time in job plans for their educational roles. The Trust allocation was 0.25 of programmed activities (PA) per trainees but there was not always dedicated time in job plans, which resulted in educational supervisors staying later than planned. The educational leads reported that there was no dedicated training space within the hospitals; offices were shared and the majority of people used open plan offices. This meant that there was no area for private meetings to complete appraisals and educational supervision. The paediatrics educational leads commented that the space they used to have had been taken away so there was no longer room for private discussions or teaching. It was difficult to hold teaching in the education centre as the bleeps did not work. There were many trainees in the department and there were a lot of educational sessions within the department, but consultants completed work in their own time as there was no dedicated time in job plans.	The Trust are required to demonstrate that time for educational supervision is clearly identified in the job plan of all educational supervisors The Trust is required to review the allocated private space in the hospitals to ensure there is dedicated space available to conduct educational supervision meetings and appraisals.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement
6	TWR 6.2	**Induction** The visit team heard that the associate director of medical and dental education was responsible for the induction programme. The statutory mandatory training and clinical skills was on the first day of induction. There had been a move towards the Trust induction being inter-professional. The induction was held weekly and the first Wednesday of the month		

		was reserved for doctors in training. All trainees had access to the eLearning modules prior to starting in post but were not expected to complete this before starting in post. The trainees reported that they had all attended a timely induction. The majority of the Trust induction had been online, and trainees indicated they were expected to complete this before starting in post.		
6	TWR 6.3	**Staffing** The senior management team reported that there was a move in the Trust towards consultants undertaking seven day working. All diagnostics were now on a seven day schedule. The Trust had a high level of cover across all hospitals, and was in a beneficial position in which cover was provided. The trainees reported that when there had been rota gaps, locums had been appointed. The site manager had called the surgery trainees and had asked them to ring the locum agency as they did not know who to escalate to, and it was not their remit. The trauma and orthopaedics trainee ended up calling all the core surgery trainees to ask for them to act as locum to cover the rota. The educational leads commented that if a doctor did not attend their shift, it was the responsibility of the human resources employee within the division to address staffing gaps. The visit team heard that the service managers were not always reliable at finding a suitable locum. The teams had often telephoned the regularly used locums.	Locum management (recruitment) needs to be responsive and responsibilities out-of-hours clearly defined and should not be delegated to trainees. Trust to provide a written policy disseminated to trainees on locum policy.	**Amber** Mandatory Requirement
6	TWR 6.4	**Out of Hours** The trainees reported that critical care outreach was good. The intensive care unit doctors reviewed any deteriorating patient out of hours; the threshold for this was low. The night and weekend cover was well staffed and the handover satisfactory. There were two 'hospital at night' meetings overnight, each attended by the multi-disciplinary team. The morning handover was consultant-led and the senior trainees were involved. The trainees reported that the hospital at night was good. The team and the system felt well supported. The trainees in anaesthetics reported that the support of the critical care outreach team was good. Initial contact with the team was through the specialist nurse. There was a good evening handover between the intensivist and anaesthetists.		

6	TWR 6.5	**Workload** The trauma and orthopaedic trainees reported that they received a good experience, but there was an issue with the number of senior trainees available. This was raised in clinical governance meetings; the site manager was unaware of how to recruit locums and there had been on-going concerns with theatre allocation and cover arrangements. The trainees in paediatrics stated that they had a high administrative workload. They often had to call parents back with information and to clarify treatment plans, which affected the morale of trainees. However, the clinical exposure was good. The educational leads stated that trainees had administrative duties, but they were clinically relevant. Paediatric oncology trainees were spending time retrieving patient results and communicating these to parents. The team were looking at ways to address this, and seeing if results could be automatically downloaded.	The Trust to review the proportion of trainees' time spent doing purely administrative work and the opportunities for learning. LFG should review if the burden can be appropriately reduced by induction of physician assistants or advanced nurse practitioner (ANP).	**Amber** Mandatory Requirement
6	TWR 6.6	**Training** The education team commented that the Trust was keen to utilise simulation in as many aspects as possible. The simulation leads had introduced inter-professional full immersion simulation for core medicine and foundation trainees. The simulation leads had been utilising lessons learnt in clinical practice simulation training for human factors. Trainees commented that there were regular teaching opportunities within the Trust. Paediatric trainees commented that they had undertaken simulation training with the nurses from the department, and the neonatology reported that they attended fortnightly multi-professional sessions.		
6	TWR 6.7	**Regional Training and Study Leave** The trainees commented that the Trust's approach to study leave funding and allocation was a fair and transparent approach. No trainees raised concerns with attending regional study days.		
6	TWR 6.8	**Undermining** The education team commented that if trainees felt undermined or bullied it was expected that they would raise concerns to their educational supervisors. There was also a confidential helpline that could be called. At the time of the visit a trainee and psychologist	DME to support the Medical Microbiology team in reviewing the format of feedback offered in the lunchtime meetings.	**Amber** Mandatory Requirement

		were undertaking an audit looking at the perceptions of bullying and undermining, and communications between professions. The chief executive stated that undermining and bullying were regularly discussed at the Trust board. These behaviours were a particular theme in London and teaching hospitals in general. The senior management team indicated that they were aware of the possible impact on staff behaviours and attitudes of aiming to be the best at the clinical services. The chief executive commented that the Trust reviewed the yearly staff survey. Expectations were high and every year efforts were made to review the Trust's policy and tolerance. Trainees in medical microbiology commented that the lunchtime meetings within the specialty were often uncomfortable, and bordered on undermining. The educational leads stated that they felt that they encouraged trainees to report undermining or bullying behaviours, and they hoped that trainees did feel supported to raise issues in confidence.		
7	TWR 7.1	**Educational Strategy** The associate director of medical and dental education provided a presentation on the Trust's educational strategy including the restructuring of medical and dental education services had been undertaken following an independent review. The visit team heard that the medical education manager (MEM) managed three training programme managers who were each aligned to a clinical board for administrative support. This was set up as it was felt that internally in the organisation, staff members were not aware of whom to raise concerns to regarding postgraduate medical education. The new set-up had improved the understanding. The trainees and trainers fed into the LFGs, which were chaired by the educational leads in the directorate or specialty. These fed into the three medical education committee meetings which were chaired by the director of medical education, who shared information with the director of education who would raise it to the Board via the director of workforce. The associate director of medical and dental education stated that the educational focus of the Trust had improved in the previous six months to the visit. The director of education role had a remit across the Trust for all professions, and this was bringing together and reshaping simulation and clinical skills provisions. The DME reported that the induction for the role included meeting education leads and regular meetings had been set up with the director of education for handover.		

		The senior management team confirmed that there were four directorates which fed into the executive board; medicine, specialty hospitals, surgery and cancer services and corporate functions. The Trust had developed the social media slogan #UCLHFuture which was the Trust's vision to embed education into all systems within the Trust and improve the organisational development. The trainees stated that the trainers and the Trust were clearly committed to training, and there was clear engagement in providing world class training.		
7	TWR 7.2	**Service Reconfigurations** The director of education provided the visit team with a presentation regarding the service reconfigurations within the Trust. The Trust set ten objectives per year and developing education was a key component. The Trust aimed to improve the satisfaction of medical education programmes, including those trainees that moved frequently (for example, foundation and core medicine programmes). The visit team heard that the Trust was based over eight sites; the main campus was the University College Hospital and Elizabeth Garrett Anderson wing. The new cancer centre being developed was named as the UCH Macmillan Cancer Centre. The Heart Hospital was being redeveloped as the University College Hospital at Westmoreland Street, which would be home to urology services once cardiology services had fully moved to Barts Health NHS Trust. The trainees in haematology and oncology indicated that they were aware of the expansion of the Trust in cancer services but many discussions within the department had been informal. Trainees stated that following the reconfiguration of cardiology services there had been no formal communications that trainees were aware of, and the majority of updates were via rumours. The radiology trainees commented that they had attended the Heart Hospital for scanning, and so the move of cardiothoracic patients to the London Clinic had directly affected the trainees. Communications regarding the new set up for radiology had not been clear, as far as trainees were aware nothing had been decided at a higher level. The visit team heard that the trainees had also not been kept up to date regarding the move of urology services to the Heart Hospital (to be known as UCH at Westmoreland Street). They were aware the move was imminent but cover arrangements had not been communicated. This had been raised to the college tutor.	The minutes of the educational committee meetings where the impact of service reconfiguration is discussed including trainee reps view is shared with all trainees, TLD and a summary provided to quality team. This is especially relevant to cardiology, haematology-oncology, pathology, radiology and urology.	**Amber** Mandatory Requirement

8	TWR 8.1	**Educational Resources** The education team stated that the working relationship with University College London (UCL) Libraries had improved. The two organisations were now more actively working together. A library development group had been established which was looking at the links between the library services, the results of GMC NTS and clinical incidents to see what resources could be developed. The library induction was now being delivered by UCL, and as a result was more informative to trainees. The visit team heard that a new doctors' mess had been made available in the main building at UCLH. The visit team learnt that the Trust was looking to invest in an improved information technology (IT) system. The chief executive had shortlisted two companies and following meetings planned for the summer of 2015, the Trust planned to issue a contract for implementation of a new system in Autumn 2015. The trainees commented that although there were many computers within the Trust, there were often difficulties with accessing guidelines on the Trust intranet. Trainees in paediatrics commented that some guidelines were off line as they were being updated. Although this had not resulted in any patient safety concerns, trainees reported that the access to the online portal for educational resources, Athens was poor. The educational leads commented that there was a lack of on-site postgraduate library facilities. There were no facilities to hold grand rounds in the Trust, as there were no lecture theatres. The only rooms to be used were in the Educational Centre or University of College London. The neonatal educational leads reported that they had fought hard but had received dedicated educational space in the department. This was used for training which included the nursing staff.	The visit team heard that some guidelines on the intranet were difficult to find or were not up to date. The Trust is required to improve access to guidelines on the intranet and provide a review from the trainee representatives.	**Amber** Mandatory Requirement

Good Practice	Contact	Brief for Sharing	Date
The Trust has developed a robust process for learning from incidents and providing regular feedback on lessons learnt. This should be commended.	Director of Medical Education	Please provide information regarding this possible good practice, which could be shared across the region.	2 September 2015
The simulation leads had introduced inter-professional full immersion simulation for core medicine and foundation trainees. The simulation leads had been utilising lessons learnt	Director of Medical	Please provide information regarding this possible good practice, which could	2 September 2015

in clinical practice simulation training, for human factors.	Education	be shared across the region.	
The medical director's open forum with trainees arranged on a regular basis should be commended.	Director of Medical Education	Please provide information regarding this possible good practice, which could be shared across the region.	2 September 2015
The intensive care unit doctors reviewed any deteriorating patient out of hours; the threshold for this was low. The night and weekend cover was well staffed and the handover satisfactory. There were two 'hospital at night' meetings overnight, each attended by the multi-disciplinary team. The morning handover was consultant-led and the senior trainees were involved.	Director of Medical Education	Please provide information regarding this possible good practice, which could be shared across the region.	2 September 2015

Other Actions (including actions to be taken by Health Education North Central and East London)

Requirement	Responsibility
N/A	

Information and reports provided to the team prior to the visit

DME Annual Report	*no*	Regulator Reports/Data	*no*	LFG Reports	*no*	MEM minutes	*yes*
GMC Survey - trainees	*yes*	GMC Survey - trainers	*no*	Previous visit reports & action plans	*yes*		

Signed

By the Lead Visitor on behalf of the Visiting Team:	Dr Indranil Chakravorty
Date:	4 August 2015